COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

CHART Phase 2:

Implementation Plan

HealthAlliance Hospital

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Version: 4

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Key personnel

Name	Title	CHART Phase 2 Role
Deborah Weymouth	President and Chief Executive Officer	Executive Sponsor
Paul MacKinnon, PhD, RN, FNP	Chief Operating Officer	Clinical and Operational Investment Director
La Shanda Anderson-Love	CHART Program Manager / Lead Analyst	Project Manager
John Bronhard	Chief Financial Officer and Treasurer	Financial Designee

Target population

Definition*:

- Adult Primary and/or Secondary Emergency Department Behavioral Health patients who are identified as high risk of an Emergency Department revisit

Quantification

- 7,000 ED visits per year

* Target population definition includes all payers and ages 18+; excluding OB, deaths, transfers to acute inpatient, and discharge to acute rehab. Excludes patients and/or visits with “Tobacco Use Only” (305.1) as the only BH diagnosis

Aim Statement

Primary Aim Statement

Reduce 30-day ED revisits by 15% for patients identified as high risk with a primary and/or secondary behavioral health diagnosis by the end of the 24 month Measurement Period.

Secondary Aim Statement*

Reduce ED LOS by 31% for ED patients identified as high risk with a primary and/or secondary behavioral health diagnosis by the end of the 24 month Measurement Period.

*Your secondary aim statement is a performance measure only and is not tied to Achievement Payment.

Baseline performance – ED utilization reduction

		Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Avg.
All	All ED Visits	3,127	2,831	3,137	3,142	3,197	3,258	3,376	3,357	3,287	3,266	2,899	3,385	**3,189**
	All ED revisits	636	553	674	608	652	634	705	680	706	661	608	764	**657**
	Revisit Rate	20%	20%	21%	19%	20%	19%	21%	20%	21%	20%	21%	23%	**21%**
	LOS (min)	207	220	204	215	193	208	191	182	202	194	185	207	**201**
Target Pop	Target Pop ED Visits	607	502	603	575	638	601	621	552	582	561	550	576	**581**
	Target Pop ED revisits	175	152	186	161	199	197	189	164	175	166	169	194	**177**
	Revisit Rate	29%	30%	31%	28%	31%	33%	30%	30%	30%	30%	31%	34%	**31%**
	LOS (min)	277	308.5	275	311	271	296	261	260	302	315	276.5	305	**288**

NOTE: The Tobacco Use Only Dx Code 305.1 is an exclusion for the target population, if it is the only BH Dx present on the Visit

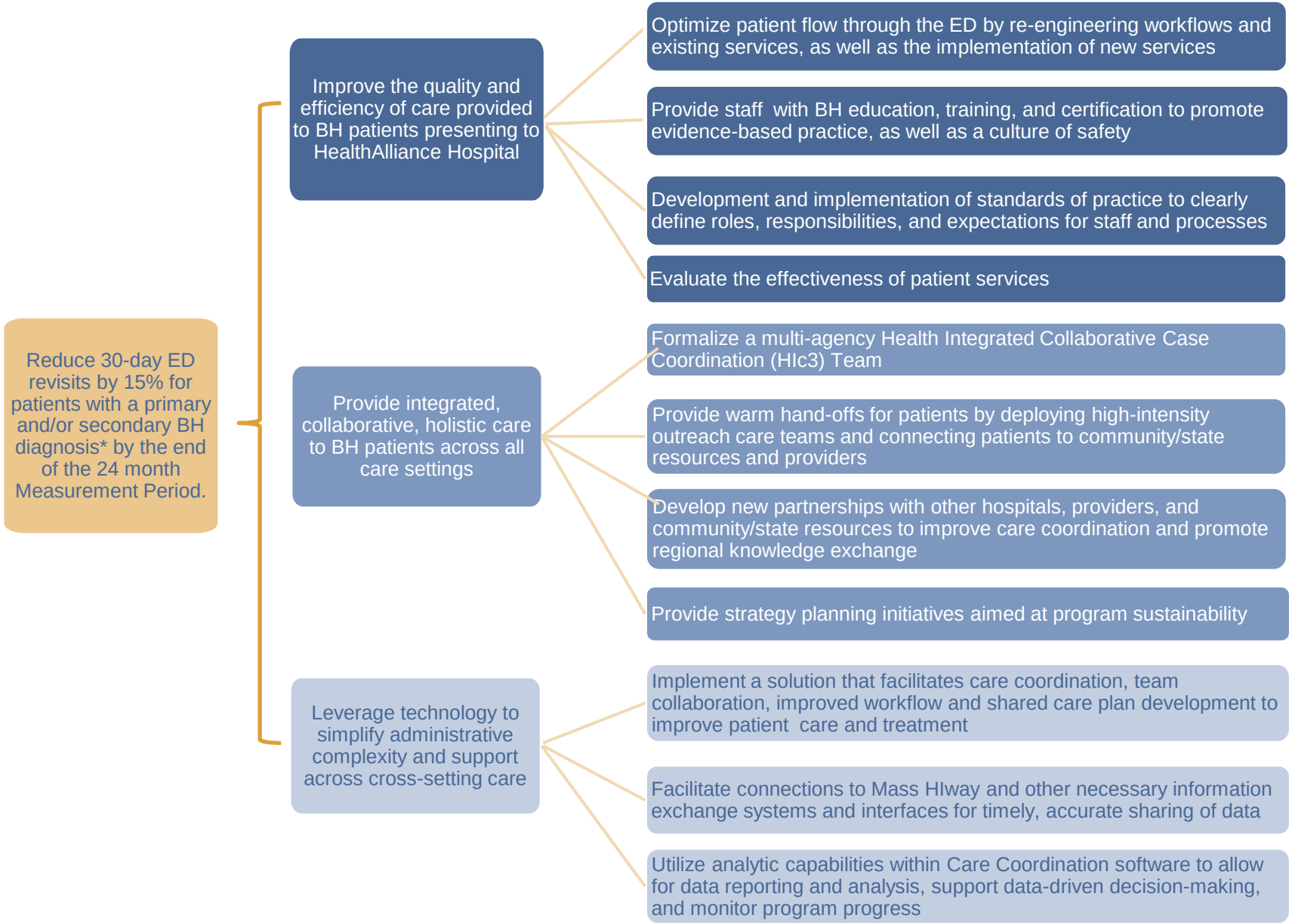
Estimated monthly impact

	Current Expected Served	Current Expected	New Expected Avoided Events	New Expected Events
Reduce 30-day ED revisits	***581 ED visit discharges*** *served per month by the HIc³*	*Given an **average revisit rate of 31%**, we expect 0.31 * 581 = 180 revisits per month.*	*Given a goal of **15% reduction** of revisits, we expect a 0.15 * 180 = 27 avoided revisits per month*	*Then, we expect 180 – 27 = 153 revisits per month*
Reduce ED LOS	***581 ED visit discharges*** *served per month by the HIc³*	*We expect a **median LOS of 288 minutes**.*	*Given a goal of **31% reduction** of ED LOS, we expect a .31 * 288 = 89 avoided minutes*	*Then, we expect 288 – 89 = 199 minutes median LOS*

	Events Avoided	Costs Avoided	ROI
Reduce ED revisits	27 avoided revisits per month x 24 months = **648 revisits/year**	648 visits x $2,000 per revisit = **$1.29M avoided**	($1.29M + $1.30M) / $3.8M = **0.68**
Reduce LOS	89 avoided minutes per discharge x 581 discharges per month x 24 months = **1.24M minutes**	1.24M minutes x $1.05 per minute = **$1.30M avoided**	

NOTE: Data results are based on all discharges from Jan 1, 2014 to Dec 31, 2014

Driver Diagram



* Target population definition includes all payers and ages 18+; excluding OB, deaths, transfers to acute inpatient, and discharge to acute rehab. Excludes patients and/or visits with "Tobacco Use Only" (305.1) as the only BH diagnosis

Service model – Overview (1 of 8)

Narrative description

During CHART Phase II, HealthAlliance Hospital, in collaboration with its partnering agencies, will employ a comprehensive set of services in order to reduce the revisit rate and LOS for the 581 patients who present to the HealthAlliance Emergency Department each month with a Primary and/or Secondary Behavioral Health diagnosis. This diagnosis group includes both Mental Health and Substance Use Disorders. Services will be initiated in the HealthAlliance Emergency Department as patients are identified and will continue in the community upon discharge, regardless of whether the patient is discharged (home, detox, crisis stabilization, etc.), admitted to a Med/Surg unit, or transferred to an Inpatient Psychiatric facility. These services are divided into two models: Hospital-Based Services and Community-Based Services. An executive oversight team has been established to provide clinical oversight and supervision for both service models, as well as to participate in program development activities, ensure partnership involvement, and remove any potential barriers that may impact the program's success.

Service model - Hospital-based initial visit (2 of 8)

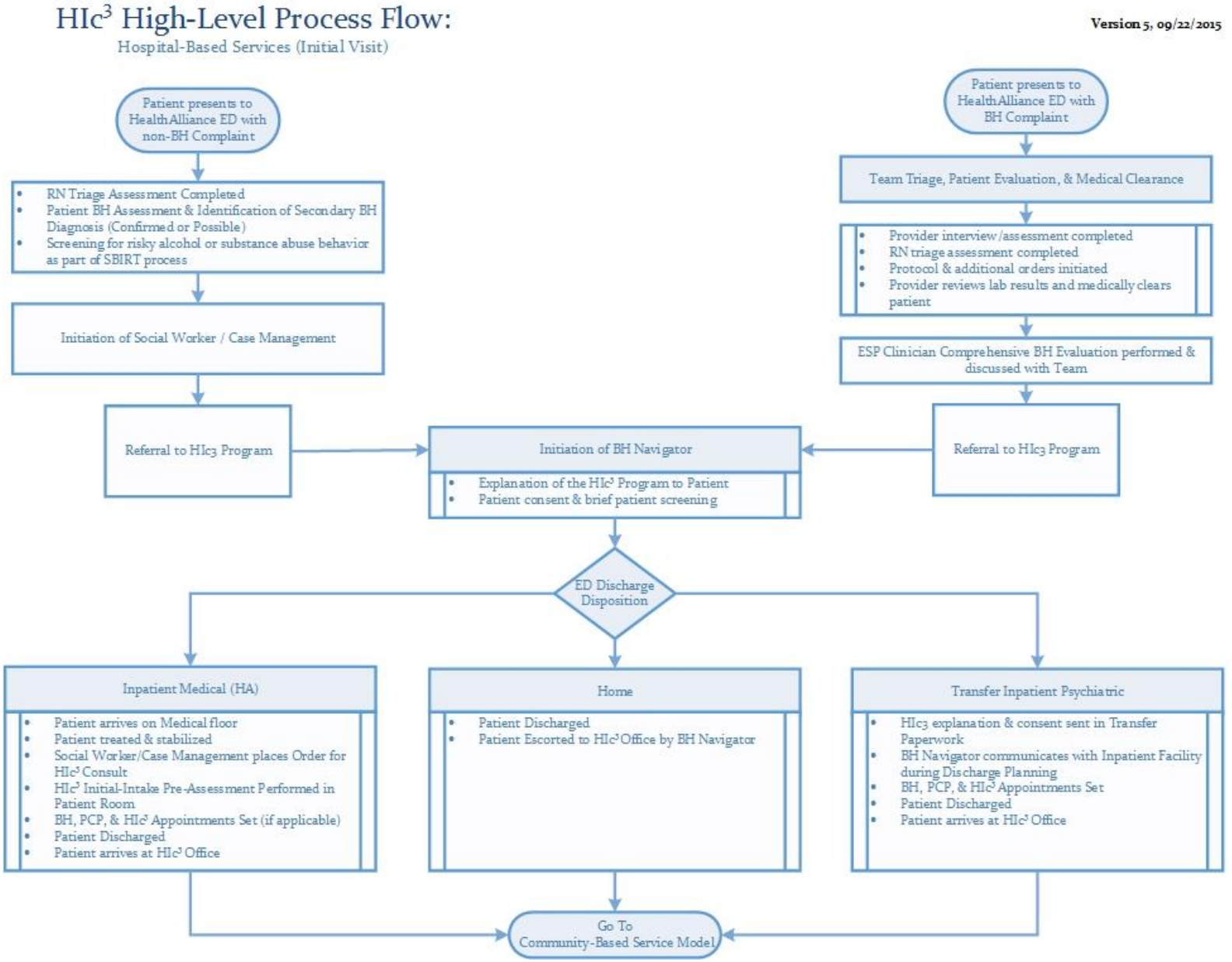
Narrative description

Patients can enter the Hospital-Based service model via one of two tracks. The first track involves patients coming to the HealthAlliance Emergency Department with a Behavioral Health chief complaint. These patients are registered, identified as Behavioral Health Patients, and brought to the Behavioral Health area of the ED. As part of CHART II, a Team Triage approach will be implemented, inclusive of a dedicated CHART Nurse Practitioner/Psychiatric Clinical Nurse Specialist (supported by the Emergency Department Physician) to expedite the medical clearance process. Once a patient has been medically cleared, a CHL ESP Clinician will perform a behavioral health evaluation and a discharge disposition will be decided. A Psychiatrist will be available as a consult throughout the assessment, evaluation and treatment process as needed.

Patients entering via this track will automatically trigger a CHART Behavioral Health Navigator Consult order. A CHART Behavioral Health Navigator will perform a brief screening of the patient to educate him/her about the HIc3 program and obtain consent. Services will then vary, according to discharge disposition. Patients being discharged home will be quickly discharged and escorted to the HIc3 office (on the hospital campus) for an Initial Intake Assessment, as well as the setting of Primary Care, Behavioral Health, and subsequent HIc3 appointments as necessary. Patients being admitted for Medical/Surgical care will be transported to their inpatient bed for treatment. Once the patient has been stabilized, the Inpatient RN or Case Manager will consult the HIc3 office. The CHART Behavioral Health Navigator will meet with the patient in their inpatient room to perform a brief screening, determine immediate service needs, and assist with discharge planning. For those patients being transferred to an Inpatient Psychiatric Facility, the CHART Lead Behavioral Navigator will ensure that the patient consent form and HIc3 program information are included in the facility transfer envelope. The CHART Lead Behavioral Health Navigator will work with the receiving facility to coordinate care for the patient as part of discharge planning, including the setting of an appointment at the HIc3 office to complete an Initial Intake Assessment.

The second track is for patients presenting to the Emergency Department with a medical chief complaint, and have a previously coded secondary diagnosis or possible underlying behavioral health condition. These patients will be triaged, assessed medically and screened for risky alcohol and substance abuse behaviors as part of the SBIRT process. The Emergency Department RN or Emergency Department Case Manager will inform patients about the CHART HIc3 program and place an order for a CHART Behavioral Health Navigator consultation.

Service model - Hospital-based initial visit graphic (3 of 8)



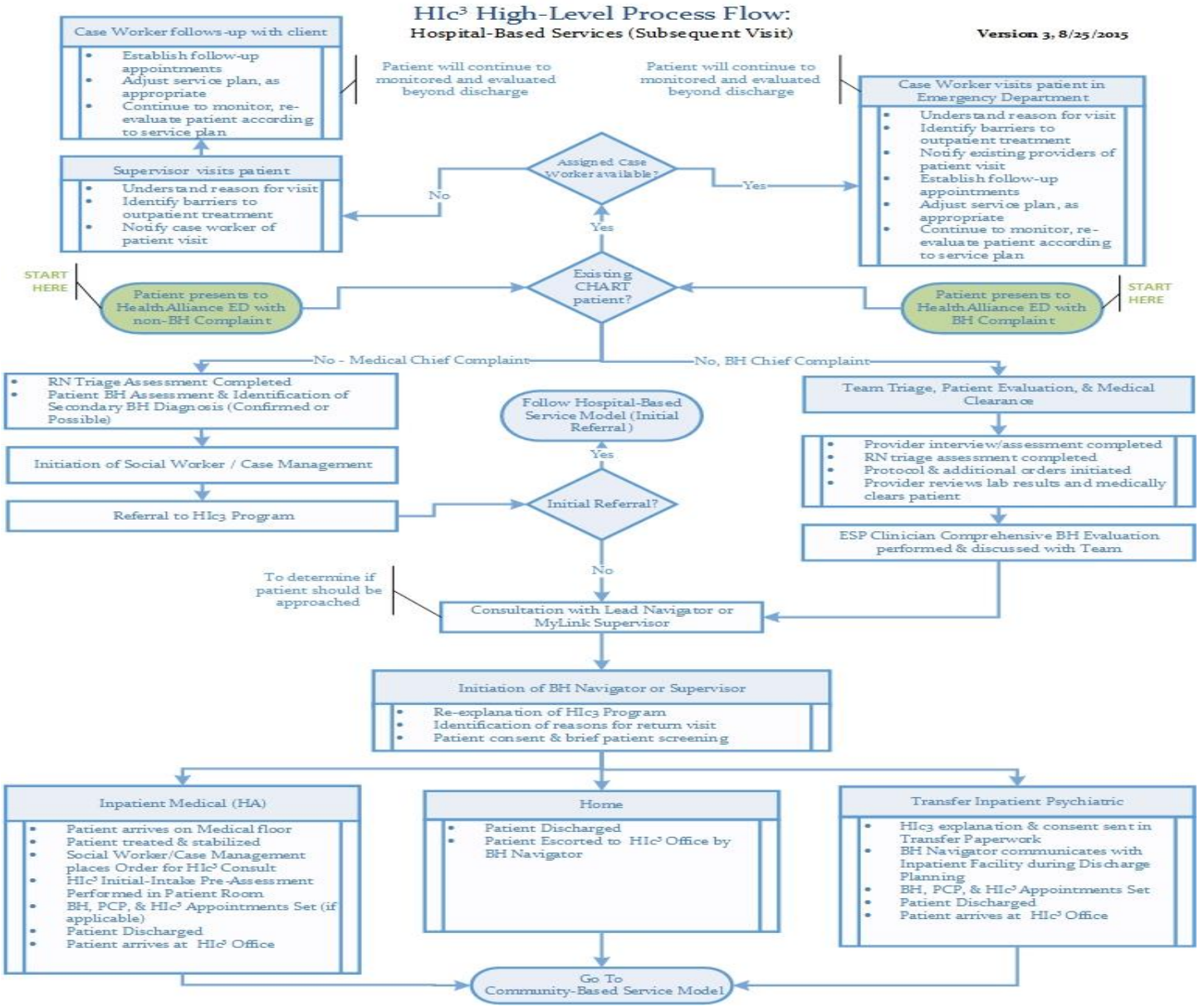
Service model - Hospital-based subsequent visit (4 of 8)

Narrative description

Patients who have a subsequent Emergency Department visit have a slightly different hospital-based service model to accommodate their needs. Any existing CHART patient who presents to the Emergency Department will automatically trigger a notification to their assigned Case Worker. The CHART Case Worker will visit the patient in the Emergency Department, understand the reason for revisit, identify any barriers to patient engagement with outpatient treatment/services, and establish all necessary follow-up appointments at discharge. The CHART Case Worker will also work with the patient to adjust the treatment plan and/or patient pathway accordingly and may seek guidance from the CHART Lead Behavioral Health Navigator. If the patient's assigned CHART Case Worker is not available at the time of the patient's visit, the CHART Lead Behavioral Health Navigator or the CHART MyLink Supervisor will meet with the patient in order to understand their reason for revisit and assess any barriers to engagement with outpatient treatment/services. They will then follow-up with assigned CHART Case Worker for next steps. This process may vary depending on shift and coverage.

Patients who present to the Emergency Department, but have not previously consented to CHART services will be triaged and assessed as described in the Initial Visit model on slide 10. Upon consult, the CHART Behavioral Health Navigator's interaction with the patient will be tailored to understanding the patient's reason for revisit and re-explaining the CHART program. The goal of this interaction is to utilize motivational interviewing techniques to increase the likelihood in the patient accepting CHART services. Patients who consent to CHART services will then follow the same track as the Initial Visit model, with services provided based on discharge disposition.

Service model – Hospital-based subsequent visit graphic (5 of 8)



Service model - Community-based (6 of 8)

Narrative description

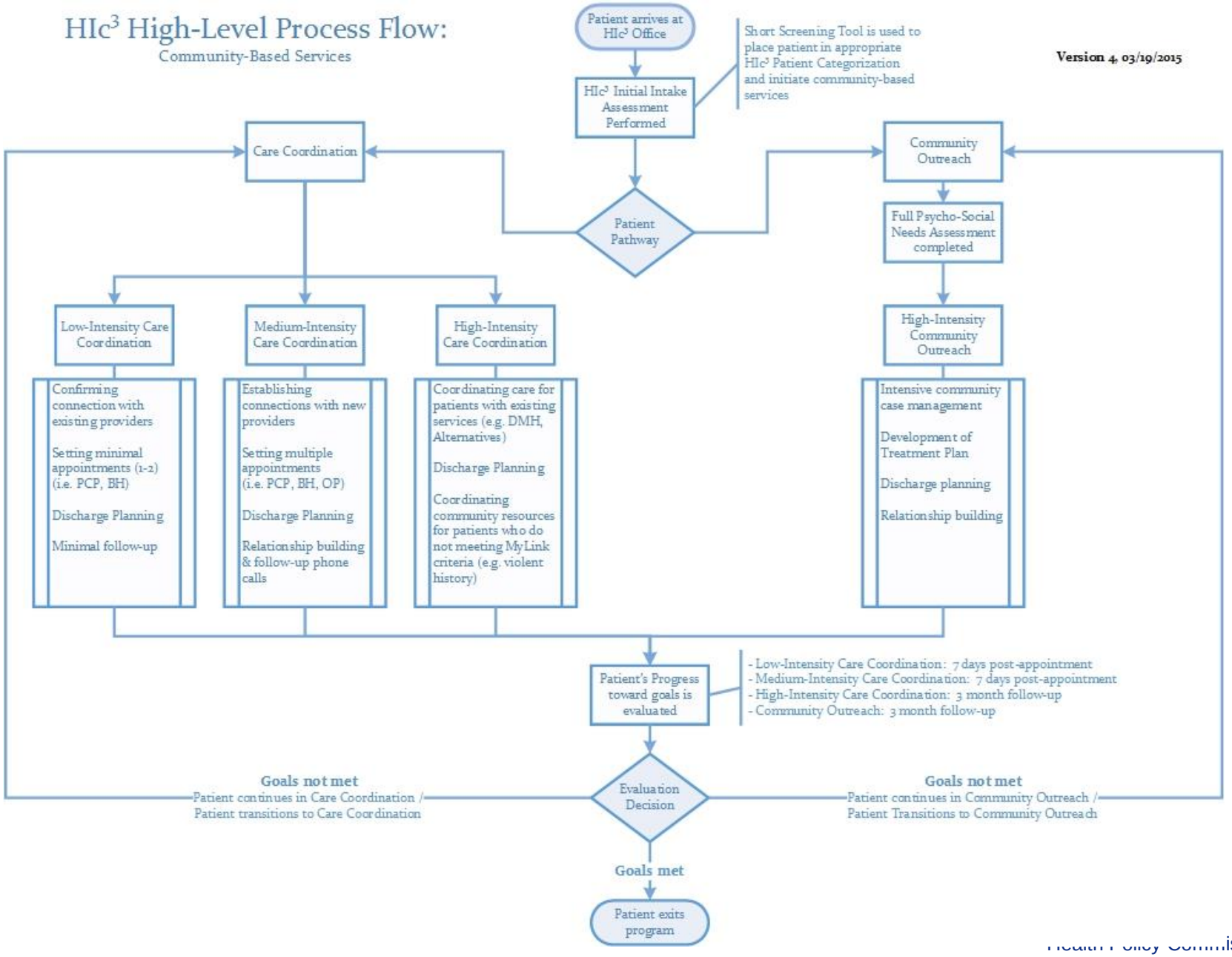
Upon discharge, services are continued in the Community-Based Services model, beginning with the completion of a Brief Patient Screening which will be utilized to determine the pathway for the client: Care Coordination or Community Outreach.

Clients in the Care Coordination pathway will be further categorized and assigned a CHART Case Worker based on the intensity of services needed. Low-Intensity clients will be those individuals who already have established care providers and only require the confirmation of those connections through the setting of follow-up appointments and discharge planning. Medium-Intensity clients are those individuals who will need the HIc3 staff to establish connections with Primary Care and/or Behavioral Health providers as well as other resources, set multiple appointments, and provide discharge planning. Both Low and Medium-Intensity clients will have follow-up post appointments and will be exited from the program if they have been compliant with their discharge plans. Patients who are non-compliant may be moved to a more intensive patient pathway. High-Intensity Clients are those more complex cases and will include patients with existing services (e.g. DMH, Alternatives), as well as those who are in need of extensive Community Outreach, but do not meet MyLink community outreach criteria (e.g. violent history). These patients will require extensive discharge planning and follow-up, as well as coordination with multiple partners and agencies. A full Psycho-Social assessment will be completed in order to develop a treatment plan and the patient will be re-evaluated on a 90 day cycle to determine progress toward their goals. These High-Intensity patients will be managed by a licensed CHART Lead Behavioral Navigator who will also provide clinical oversight and supervision for the other CHART Behavioral Health Navigators.

Clients in the Community-Outreach pathway will first have a full Psycho-Social Needs Assessment completed in order to assist with the development of treatment plan Once completed, clients will be assigned a CHART MyLink Community Health Worker who will provide intensive, community-based case management and will re-evaluate the patient every 90 days at minimum. It is important to note that patient pathways are flexible, not static and that following re-evaluation, patients can continue on their existing pathway, transition to another pathway, or exit the program depending on their progress toward goals. A licensed CHART MyLink Supervisor will be in place to provide clinical oversight for the CHART Intake Coordinators, as well as the CHART MyLink Community Health Workers. This oversight includes sign-off on completed intakes, assessments, and treatment plans. Supervisory roles will also be involved in care planning initiatives, program monitoring, and staff supervision.

Care Plans will also be developed for a subset of the CHART patients. ED-Specific Care Plans will be developed for difficult to manage patients, as well as high-utilizers. Comprehensive, Community Care Plans will be developed for High-Intensity Care Coordination and Community Outreach patients who are high-utilizers and/or are not progressing toward their treatment plan goals.

Service model - Community-based volume projections (7 of 8)



Service model - Other services (8 of 8)

Narrative description

In addition to the direct care services provided, both in the Emergency Department and out in the Community, there will also be services put in place that will be aimed at knowledge building and improved efficiencies. These services include extensive staff education, the implementation of Care Coordination software and the redesign/streamlining of existing workflows. The program will also work to leverage technology to seamlessly exchange and analyze the information will be necessary to reduce administrative complexities. Having information readily available as well as the integration of intelligence within the workflow for managing/monitoring program performance will be essential to improving the processes and ultimately to the program's outcomes.

Service worksheet

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Service mix – CHART funded (1 of 2)

Role	Organization	Funding	FTEs	Shift(s)	Responsibilities
CHART Behavioral Health Program Specialist	HealthAlliance	CHART	1.0	7am-4pm	• Audit paper and electronic medical records for Behavioral Health patients and analyze results for process improvement • Identify deviations from HIc3 Policies and Procedures • Document audit activities within HIc3 Care Coordination Software • Assistant to HIc3 Project Team
CHART Behavioral Health Nurse Practitioner / Psychiatric Clinical Nurse Specialist	HealthAlliance	CHART	1.75 (contracted)	8am-6pm	• Assess and triage behavioral health patients • Provide consultation to ED staff and HIc3 team • Provide medical clearance for behavioral health patients • Participate in Care Plan development • Actively work with patient treatment providers to establish treatment/management plan while in the ED inclusive of prescribing medications

CHART Behavioral Health Lead Navigator	HealthAlliance	CHART	1.0	8am-5pm Mon-Fri	• Coordinate care for High-Intensity Care Coordination Patients, including:
					  ○ Consulting with existing services and providers to indemnify service gaps
					  ○ Establishing Primary Care and Behavioral Health appointments
					  ○ Coordinating intensive community support services
					  ○ Performing routine, intensive follow-up (phone or onsite at Hic3 office)
					• Provide supervision and clinical oversight for BH Navigators and participate in performance reviews
					• Assist with Inpatient Psychiatric transfers and discharge planning
					• Facilitate Care Plan development
					• Document within HIc3 Care Coordination Software

CHART Behavioral Health Navigator	HealthAlliance	CHART	3.4	7am-9pm Mon-Sun	• Educate/orient patients to the HIc3 program
					• Perform HIc3 Brief Screening with patients
					• Coordinate care for Low & Medium-Intensity Care Coordination Patients, including:
					  ○ Establishing Primary Care and Behavioral Health appointments
					  ○ Coordinating minimal community support services
					  ○ Performing routine follow-up after appointments
					• Provide Brief Interventions and Referrals for treatment as part of the SBIRT process
					• Document within HIc3 Care Coordination Software

CHART Security Officer	HealthAlliance	CHART	2.1	9am-9pm Sun-Sat	• Provide security for the CHART office's clients, visitors, employees, and partner staff • Monitor CHART office security cameras and intervenes as needed

Service mix – CHART funded (2 of 2)

Role	Organization	Funding	FTEs	Shift(s)	Responsibilities
CHART MyLink Supervisor	CHL	CHART	0.94 (contracted)	8am-5pm Mon-Fri	• Supervision and clinical oversight for Intake Coordinators • Supervision and clinical oversight for MyLink Community Health Workers • Participate in Care Plan meetings as needed
CHART Intake Coordinator	CHL	CHART	1.4 (contracted)	9am-5pm Mon-Sun	• Educate/orient patients to the HIc3 program • Perform HIc3 Brief Screening and Intake assessments • Assign Patient Pathway • Assign clients to Care Coordination resources • Refer Community Outreach clients to supervisor for Community Health Worker assignment • Document within HIc3 Care Coordination Software
CHART MyLink Community Health Worker	CHL	CHART	5.6 (contracted)	8am-5pm Mon-Fri	• Perform comprehensive, whole-person assessments • Develop client treatment plans based on patient needs and assessments • Provide intensive community outreach and case management for patients who meet MyLink criteria • Document within HIc3 Care Coordination Software
CHART Behavioral Health Case Manager	CHC	CHART	1.8 (contracted)	8am-8pm Mon-Fri 8am-3pm Sat	• Schedule Primary Care and Behavioral Health appointments for patients/clients utilizing CHC providers • Provide warm handoffs to CHC staff • Provide Care Coordination for Low and Medium Intensity clients who utilize CHC only for PCP and BH care • Document within HIc3 Care Coordination Software
# FTE/units of service hired at my organization					**7.5**
#FTE/units of service contracted					**11.49**

Service mix – In-kind contributions (1 of 2)

Role	Organization	Funding	FTEs	Shift(s)	Responsibilities
Investment Director	HealthAlliance	HA	.15	NA	• CHART Clinical and Operational Investment Director
Chief Nursing Officer	HealthAlliance	HA	0.08	NA	• Provide clinical oversight for CHART II initiatives
Emergency Department Director	HealthAlliance	HA	0.30	NA	• Provide clinical oversight for CHART II initiatives • Provide supervision of all ED staff • Participate in HIc3 program design and process improvement
Emergency Department Physician	HealthAlliance	Contractor	2.45	6pm-8am & as needed	• Assess and triage behavioral health patients during non-CHART Team Triage hours and as needed • Provide medical clearance for behavioral health patients during non-CHART Team Triage hours and as needed • Provide supervision/consultation to Nurse Practitioner as needed
Consulting Psychiatrist	HealthAlliance	Contractor	0.08	24 hour coverage	• Provide consultation to Nurse Practitioner and Behavioral Health team as needed • Participate in Care Plan meetings • Conduct psychiatric evaluations in the Emergency Department as needed
Behavioral Health Registered Nurse	HealthAlliance	HA	4.20	24 hour coverage	• Participate in Team Triage, patient assessment, and treatment for patients presenting to the Emergency Department with psychiatric chief complaints • Provide universal screening for risky alcohol and substance abuse behaviors as part of the SBIRT process • Consult the CHART program as needed
Emergency Department Registered Nurse	HealthAlliance	HA	4.25	24 hour coverage	• Triage, assess, and treat patients presenting to the Emergency Department with medical chief complaints and a Secondary Behavioral Health diagnosis • Provide universal screening for risky alcohol and substance abuse behaviors as part of the SBIRT process • Consult Case Management, Social Work, and the CHART Program as needed
Case Manager & Social Worker	HealthAlliance	HA	1.6	8am-5pm Sun-Sat	• Consult the CHART program, as needed for patients presenting to the HealthAlliance Emergency Department with Medical chief complaints • Consult the CHART program, as needed for patients admitted to HealthAlliance hospital

Service mix – In-kind contributions (2 of 2)

Role	Organization	Funding	FTEs	Shift(s)	Responsibilities
Vice President of Children & Emergency Services	CHL	CHL	.08	NA	• Provide oversight for the CHL component of Care Coordination and ES operations • Provide supervision of all staff • Participate in HIc3 program design and process improvement
Emergency Services Director	CHL	CHL	.08	NA	• Provide oversight of the CHL emergency services component of Care Coordination • Supervise CHL emergency services staff • Participate in HIc3 program design and process improvement
MyLink Director	CHL	CHL	.08	NA	• Oversight of the CHL case management component of Care Coordination operations and supervision of CHART supervisor and staff • Participate in HIc3 program design and process improvement
Emergency Services Program Clinician	CHL	CHL	4.2	24 hour coverage	• Perform behavioral health evaluations • Act as liaison between bed search team and behavioral health office
Chief Operating Officer	CHC	CHC	.08	NA	• Oversight of the CHC component of HIc3 and supervision of all CHC staff • Participate in HIc3 program design and process improvement
Behavioral Health Director	CHC	CHC	.08	NA	• Oversight of the CHC component of HIc3 and supervision of behavioral health staff • Participate in HIc3 program design and process improvement
# FTE/units of service funded In-kind					**17.71**

List of service providers/community agencies

Type of Service Provider	Community Agency Name	New or Existing Relationship
Behavioral Health & Primary Care (new)	Community Healthlink (CHL)	Existing
Behavioral Health & Primary Care	Community Health Connections (CHC)	Existing
Primary Care	Fitchburg Family Practice	New
Note: This is not a comprehensive list of all services to be provided by partnering agencies. We are currently evaluating additional partnerships based on services providers and will be reaching out to establish partnerships with those agencies that best help our patients/clients meet their goals.		

Summary of services

Clinical service and staffing mix

In ED – BH side
- Present to BH side of ED
- Triage, ESP evaluation, medical clearance
- Refer to BH navigator
- Develop ED Care plan

In ED – Med side
- BH issue identified by RN/MD (will educate, have prompts, reminders)
- HiC3 will get alerts for all ED presentations and analytics will trigger alert for HiC3
- Consult BH navigator

For patients d/c home
- Discharge to HIC3 program office, near the ED

For patients discharged to inpatient unit
- Obtain written consent prior to transfer so that that unit will talk with program to arrange transition to community

For patients admitted to med/surg:
- RN on floor will consult HIC3 to participate in discharge planning

Once in HiC3:
- Patient will be seen by MyLink coordinator
- Screening to triage patient to 2 pathways: care coordination or community outreach based on established criteria

Care Coordination (largely telephonic, except high):
- Stratified to low, medium, high intensity based on needs and the presence of other services
- High intensity group will include bringing patients into the HiC3 office for team meetings, care planning
- Every 90 days will reevaluate their progress against their care plan

Community Outreach
- Assigned a MyLink navigator
- Every 90 days will reevaluate their progress

Cohort-wide standard measures – Hospital utilization measures

Data elements	All	Target Population
1. Total Discharges from Inpatient Status (“IN”)	x	x
2. Total Discharges from Observation Status (“OBS”)	x	x
3. SUM: Total Discharges from IN or OBS (“ANY BED”)	x	x
4. Total Number of Unique Patients Discharged from “IN”	x	x
5. Total Number of Unique Patients Discharged from “OBS”	x	x
6. Total Number of Unique Patients Discharged from “ANY BED”	x	x
7. Total number of 30-day Readmissions (“IN” to “IN”)	x	x
8. Total number of 30-day Returns (“ANY BED” to “ANY BED”)	x	x
9. Total number of 30-day Returns to ED from “ANY BED”	x	x
10. Readmission rate ("IN readmissions" divided by "IN")	x	x
11. Return rate (ANY 30-day Returns divided by “ANY BED”)	x	x

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

Cohort-wide standard measures – ED utilization measures

Data Elements	All	Target Population
12. Total number of ED visits	x	x
13. Total number of unique ED patients	x	x
14. Total number of ED visits, primary BH diagnosis	x	
15. Total number of unique patients with primary BH diagnosis	x	
16. Total number of ED visits, *any* BH diagnosis		
17. Total number of unique patients with any BH diagnosis		
18. Total number of 30-day ED revisits (ED to ED)	x	x
19. Total number of 30-day revisits (ED to ED), primary BH diagnosis	x	
20. Total number of 30-day revisits (ED to ED), any BH diagnosis		
21. ED revisit rate	x	x
22. ED BH revisit rate (primary BH diagnosis only)	x	
23. ED BH revisit rate (any BH diagnosis)		
24a. Median ED LOS (time from arrival to departure, in minutes)	x	x
24b. Min ED LOS (time from arrival to departure, in minutes)	x	x
24c. Max ED LOS (time from arrival to departure, in minutes)	x	x
25a.Median ED LOS (time from arrival to departure, in minutes), primary BH diagnosis	x	
25b. Min ED LOS (time from arrival to departure, in minutes), primary BH diagnosis	x	
25c. Max ED LOS (time from arrival to departure, in minutes), primary BH diagnosis	x	
26a. Median ED LOS for ED boarders per DPH boarder definition (patients with a primary behavioral health diagnosis who remain in the ED for 12 or more hours from ED arrival to ED departure)	x	x
26b. Min ED LOS for ED boarders per DPH boarder definition (patients with a primary behavioral health diagnosis who remain in the ED for 12 or more hours from ED arrival to ED departure)	x	x
26c. Max ED LOS for ED boarders per DPH boarder definition (patients with a primary behavioral health diagnosis who remain in the ED for 12 or more hours from ED arrival to ED departure)	x	x

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

Cohort-wide standard measures – Service delivery measures

Data elements	Target Population
27. Total number of unique patients in the target population	x
28. Number of acute encounters for target population patients	x
29. For acute encounters in measure #28, number of these with any CHART service provided after discharge and within 48 hours	x
30. Total number of contacts for the target population	x
31. Average number of contacts per patient served	x
32a. Min number of contacts for patients served	x
32b. Max number of contacts for patients served	x
33. Number of units of service provided by service modality (including, e.g., phone call, virtual interaction, face to face in office, face to face in home, etc.)	x
34. Number of units of service provided, by service types (e.g., care coordination, medication optimization, clinical care, counseling, needs assessment, etc.)	x
35. Number of units of service provided, by role type (NP, LICSW, Pharmacist, Community Health Worker, Peer)	x
36. Average time (days, months) enrolled in CHART program per patient	x
37. Range time (days, months) enrolled in CHART program per patient	x
38. Proportion of target population patients with care plan	x

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

Cohort-wide standard measures – Payer mix

Data elements	Medicare	Medicaid	Commercial
39. Count of patients in the Target Population	x	x	x

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

Program-specific measures with HPC specifications

Measure	Numerator	Denominator
Total number of any BH diagnosis ED visits discharged home	Count of ED visits that were discharged to home	N/A
Total number of any BH diagnosis ED visits admit to med/surg	Count of ED visits that were admitted to med/surg	N/A
Total number of any BH diagnosis ED visits admit/transfer to psych unit	Count of ED visits that were admitted/transferred to psych unit	N/A

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

Program-specific measures (1 of 2)

Measure	Measure Type (Program/Process)
Work list/Enrollment Eligible List	
Total # of Eligible Patients	Program
# Auto Added & Manually Added % Auto Added & % Manually Added	Process
Manual Reason	Process
% Manual by Reason	Process
% Manual by Reason Type	Process
Hlc3 Program Referrals	
Total # Referral Received (ALL)	Program
# of Referrals Received (consult orders)	Program/Process
# of Referrals Received (phone call)	Process
# of Self Referrals	Process
# of Outside Referrals	Program
> by Type (family, agency, PCP, hospital etc)	Program
Initiation of Navigator	
Total # of Patient/Navigator Interactions	Program
# of Patients by Verbal Consent Action: **Interested STAT**	Program
# of Patients by Verbal Consent Action: **Interested Follow-Up Required**	Program
> Reason (IP Transfer, Patient Request)	Program
# of Patients by Verbal Consent Action: **Declined**	Program/Process
> Decline Reasons	Program/Process
# of Patients by Verbal Consent Action: **Not Met**	Program/Process
> Not Met Reasons	Program/Process
Initial Intakes	
Total # of Patients Screened	Program
Total # of Patient Referrals (All)	Program
# of Patients by Referral Action: **Enrolled**	Program
# of Patients by Referral Action: **Declined**	Program
> Declined Reasons (Too involved, etc)	Process
# of Patients by Referral Action: **Not Met**	Program
> Not Met Reasons	Process
# of Patients by Referral Action: **Abandoned**	Program
> Abandoned Reasons (Did not continue Intake Process, etc)	Process

Program-specific measures (2 of 2)

Measure	Measure Type (Program/Process)
Patient Pathways	
Total # of Patients ALL Pathways	Program
Appts Set Appt Kept Appts Not Attended Appts Rescheduled	
Total # Care Coordination & Total % Care Coordination	Program
Appts Set Appt Kept Appts Not Attended Appts Rescheduled	
Total # Low Intensity & Total % Low Intensity	Program
Appts Set Appt Kept Appts Not Attended Appts Rescheduled	
Total # Medium Intensity & Total % Medium Intensity	Program
Appts Set Appt Kept Appts Not Attended Appts Rescheduled	
Total # High Intensity & Total % High Intensity	Program
Appts Set Appt Kept Appts Not Attended Appts Rescheduled	
Total # Community Outreach & Total % Community Outreach	Program
Appts Set Appt Kept Appts Not Attended Appts Rescheduled	
Pathway Intensity	Process
Patient Goals/Progress	Process
Patient Evaluation/Experience	Process

Continuous improvement plan (1 of 2)

1. How will the team share data? Describe.	Data will be shared during our weekly, recurring CHART II Work Session meetings. Meeting attendees include the Executive Sponsor, HealthAlliance staff, Consultants, and representation from our community partners. A dashboard will be created with metrics and graphic representations that will allow the team to track progress, identify opportunities for improvement, and readily share data with all stakeholders. The dashboard will be easily accessible and will allow for daily monitoring, as well as the sharing of data on a weekly, monthly, quarterly, or ad-hoc basis.
2. How frequently will you (PM, Investment Director) look at the data (e.g., weekly)? Describe.	The CHART II dashboard will be displayed, real-time in the PMO office to allow for constant monitoring of program progress and trends, as well as immediately recognition of program needs or opportunities for improvement. This dashboard will also be made available to all interested parties to be viewed on demand. In addition to the constant monitoring that will occur in the PMO office, data will be analyzed weekly to allow for data-driven discussion at the recurring CHART II work sessions.
3. How often will your executive team (VPs, C-suite) review CHART project reporting (e.g., monthly)? Describe.	A CHART II Project update is a standing agenda item at the weekly Senior Management Team (SMT) meetings and will include a brief review of program utilizing the dashboard reporting. In addition, the CHART PMs will present to the SMT once monthly to provide a more detailed update on progress, request SMT engagement regarding program barriers and answer any outstanding questions.
4. How often will your front line CHART staff (SW, care team) review reporting (e.g., weekly)? Describe.	Data will be shared during our weekly, recurring CHART II Work Session meetings, which include representation hospital front-line staff. This dashboard will also be made available to all interested parties to be viewed on demand.
5. How often will your community partners review data (e.g., weekly, monthly)? Describe.	Data will be shared during our weekly, recurring CHART II Work Session meetings, which include representation our community partners. This dashboard will also be made available to all interested parties to be viewed on demand. In addition, data will be shared monthly at the EMS Outpatient meeting to ensure that representatives from surrounding Police, Fire and Rescue services are aware of the programs progress and needs.
6. Which community partners will look at CHART data (specific providers and agencies)? Describe.	CHL, CHC, Leominster Police, Fitchburg Police, Lunenburg Police, MedStar, Leominster Fire, Fitchburg Fire, Lunenburg Fire, the Regional Behavioral Health Collaborative and other community partners as they are identified. As we move forward in CHART II, we will also be looking to establish a process to share data with the Primary Care Offices and Behavioral Health Providers with whom we are frequently working with to coordinate care for our target population.
7. Will the quality committee of your board review CHART reporting (e.g., quarterly)? Describe.	Yes, data will be shared on a quarterly basis and as requested. This is a continuation of the process established during CHART I. Of note, there is also board representation at the RBHC meetings and there is a board member who is invited to select CHART II work sessions to ensure that board leadership is engaged in the CHART project and aware of program progress/needs.

Continuous improvement plan (2 of 2)

8. Who will collect measures and produce reporting for Cohort-wide and program specific measure (e.g., Data Analyst, PM, ID)? Describe.	**Cohort-Wide**	**Program specific**
	La Shanda Anderson-Love (Program Manager)	La Shanda Anderson-Love (Program Manager)
9. What is your approximate level of effort to collect these metrics? Describe.	**Cohort-Wide**	**Program specific**
	Reports can be run on-demand with minimal effort (5 minutes). These reports, however, are not the ideal solution, as they do not allow for a deeper-dive to more thoroughly analyze the data as needed. For example, current system does not allow us to analyze the actual patients that make up the numbers. This type of analysis can provide a great deal of necessary data, especially in linking those patients to our program specific metrics. We can also not easily break down data into more meaningful chunks (e.g Diagnosis categories and count) .	Too early to determine.
10. How will you ensure that you are able to collect both your program specific and the cohort-wide measures? Describe.	Cohort measures are available to run now via an existing reporting tool and will be inclusive of all data requirements indicated on the previous slides once all of the programming changes have been made.	
11. How will you know when to make a change in your service model or operational tactics? Describe.	Constant monitoring of program data via dashboard reporting, coupled with staff and patient experience data will inform change. In addition, detailed discussion will also take place during the weekly recurring CHART II work sessions regarding program performance and perceived barriers to progress.	

Enabling technologies plan

Functionality	User	Vendor	Cost
Care Coordination Software (SaaS model) Implementation of CareManager, Care Connect, and Report Server to: • Automate and Streamline Patient Qualification for CHART program • Manage and Electronically Obtain Patient Consent • Automate Registration of Patient Intake and Track Encounters • Perform Collaborative Care Plan Development and Activities • Generate Weighted and Scored Patient Health Status Assessments • Automate Patient Assignment to Care Coordination Teams • Provide Access to Essential Health Record information for Community Partners through SaaS Portal • Automate Alerts and Reporting • Patient Outreach and Follow-up Activity	Hospital, Community Partner, and HIc3 team	Netsmart	$301,275 $234,050 (CHART funded)
Netsmart Training – guided practice focused on understanding the workflow and functionality of the Netsmart Care Manager, Care Connect and Report Solution	Hospital, Community Partner, and HIc3 team	Netsmart	$4,800
Measurement	HIc3 team	Optimuminsight Life Science	$7,375

Other essential investments – CHART funded

Other Investments	Cost
Training – SBIRT/MI Workshop (ED) - full day training for BH Navigators and Mylink Intake Coordinators	$1000
Training – SBIRT/MI Workshop (PCP) –for Top 10 PCPs and designated staff –estimated 24 sessions	$3600
Training – Trauma-Informed Care Strategic Planning for Trauma-Informed Care Committee (as needed not to exceed 32 hours)	$6400
Training – Informed Care Lecture- focused on understanding the effects of trauma on patient behavior, reducing the stigma, and providing a framework to prevent the re-traumatizing of patients – for All CHART roles (7, 4-hour sessions)	$8400
Training – MOAB training –classroom training and skills practice in strategies for preventing and diffusing aggressive behavior, as well as managing physical confrontations - for BH Navigators, MyLink Intake Coordinators, PMO, CHL/CHC Supervisor – 2 sessions	$208
Training – QPR training to help CHART staff recognize and respond to suicide warning signs	TBD
Microsoft Office Training – PMO staff – 17 sessions	$7250
Cost to back-fill hourly positions which participants attend training ED RN: $50.23, MHC: $20.21, Obs: $13.08, CCT: $16.25, US: $16.19	$14,928.60
IT support at community partner – Community Healthlink (CHL)	$26,000
IT support at Community Partner – Community Health Connections (CHC)	$26,000
Travel – Netsmart staff implementing enabling technology	$8,775
CHART Project Manager/Analyst (Systems & Integration)	$273,000
Enabling technology Training – training on Netsmart Care Manager, Care Connect and Reporting Solutions	$4,800
CHART Project Manager – LaShanda Anderson-Love	$363,000
Project Manager / Analyst (Workflow, Process & Education), Jennifer Davis	$126,574

Key dates

Key milestone	Date
Launch date (beginning of your 24 month Measurement Period)	11/1/2015
Post jobs	9/28/2015
New hires made	10/15/2015 and 1/8/2015
Execute contract with Netsmart	10/1/2015
Enabling technology – Netsmart testing initiated	11/12/2015
Enabling technology – Netsmart go-live (Partial Phased Approach)	12/1/15 and 2/1/16
First patient seen	11/2/15
Revisits reduction initiatives support 50% of planned patient capacity	11/2/2015
Revisits reduction initiatives support 100% of planned patient capacity	1/29/2016
First test report of services, measures	12/15/2015
New hire training, CHART training, and Netsmart training	10/30/15 and 1/29/16
Trauma-informed Care Training	7/29/16
SBIRT Training	3/30/16
Suicide Prevention Training	4/14/16
CHART Phase 2 office – new construction complete	1/4/16

Community partners and subcontractors (1 of 2)

Name	Business Address	Website	Contact Name	Contact Title	Contact Phone Number	Contact Email Address
Community Healthlink (CHL)	Community Healthlink 72 Jaques Ave. Worcester, MA 01610	http://communityhealthlink.org	Carolyn Droser	VP of Children and Emergency Services	508-421-4336	CDroser@communityhealthlink.org
Community Health Connections (CHC)	Fitchburg Community Health Center, 326 Nichols Road, Fitchburg, MA 01420	http://chcfhc.org/	Jackie Buckley	Chief Operating Officer	978-878-8502	jbuckley@chcfhc
Netsmart	1 Penn Plaza, Suite 1700, New York, NY 10119	http://www.ntst.com/	Lori Nicolosi	Client Development Executive	913-272-2630	LNicolosi@ntst.com
Impact Solutions v2, LLC	49 St. Croix Island Drive St. Augustine, FL 32092	N/A	La Shanda Anderson-Love	Program Manager / Lead Analyst	978-466-2170	lashandaandersonlove@yahoo.com
Wachusett Emergency Physicians	60 Hospital Road Leominster, MA 01453	NA	TBD – Not Yet Hired	Nurse Practitioner / Psychiatric Clinical Nurse Specialist	TBD – Not Yet Hired	TBD – Not Yet Hired
UMass Memorial Medical Group, Inc.	306 Belmont Street Worcester, MA 01604	NA	Christopher Kennedy	MD	508-856-6580	
Optimuminsight Life Science (formally known as QualityMetric Inc	24 Albion Rd, Bldg 400 Lincoln, RI 02865	https://www.optum.com/	Alicia Laplante	Account Manager	401-642-0861	alaplante@qualitymetric.com]

Community partners and subcontractors - Training (2 of 2)

Name	Business Address	Website	Contact Name	Contact Title	Contact Phone Number	Contact Email Address
Institute for Health and Recovery	349 Broadway Cambridge, MA 02139	www.healthrecovery.org	Laurie S. Markoff, Ph.D	Director of Trauma Integration Services	857-285-6268	lauriemarkoff@healthreacovery.org
Motivational Interviewing Network of Trainers	379 Thornall Street Edison, NJ 08837	www.motivationalinterviewing.org	John Brelsford	Certified Trainer	413-433-1775	jbrelsford@gmail.com
BNI Art Institute, Boston University School of Public Health Dept. of Community Health Sciences	801 Massachusetts Ave., Rm 428B Boston, MA 02118	http://www.bu.edu/bniart	Deric Topp	Assistant Director	617-414-8455	dtopp45@bu.edu
Heywood Hospital, Suicide Prevention Taskforce	242 Green Street Gardner, MA 01440	www.heywood.org/services/social-services/suicide-prevention-task-force	Anne Jasinski	Certified Trainer		Anne.Jasinski@heywood.org
MOAB Training International, Inc.	PO Box 460 Kulpsville, PA 19443	www.moabtraining.com	Nick Allain	Certified Trainer / Security Supervisor	978-466-2013	nallain@healthalliance.com
ONLC Training Centers	255 Park Avenue, Ste 1000 Worcester, MA 01609	www.onlc.com			800-288-8221	